Education for collaboration

Education for integration: four pedagogical principles

Dr Ailsa Cook, Centre for Research on Families and Relationships, University of Edinburgh; Dr John Harries, School of Social and Political Science, University of Edinburgh, UK and Dr Guro Huby, Ostfold University College, Norway.

Abstract

Purpose: This paper considers how postgraduate education can contribute to the effective integration of health and social care through supporting public sector managers to develop the boundary spanning skills required for collaborative working.

Design/ methodology /Approach: A reflection on and review of documentation from ten years of delivery of a part time postgraduate programme for health and social care managers, critical reflection on the findings in light of relevant literature.

Findings: The health and social care managers participating in this postgraduate programme report working across complex, shifting and hidden boundaries. Effective education for integration should: ground learning in experience; develop a shared language; be inter-professional and co-produced and support skill development.

Originality / Value: This paper addresses a gap in the literature relating to the educational and development needs of health and social care managers leading collaborative working.

Key words

Collaboration, boundary spanning, health and social care, integration, education

Collaboration in the context of health and social care

Across the UK and beyond, collaboration has been seen as central to delivering on the health and social care agenda (e.g. Petch, 2011). This precipitated a steady flow of activity at policy, practice and strategic levels to overcome organisational and professional boundaries and so increase efficiency and deliver seamless care through a "whole system" focus (Petch, 2008). This aspiration to better integrate health and social care services has engendered a great deal of academic commentary and many substantive studies of the factors that inhibit or enable the creation of more seamless networks across traditionally constituted organisational and professional boundaries (cf.

Cameron & Lart, 2014). A good deal of this literature has attended to ways of working, and by implication the problem workforce development.

In general the writing in this area focusses on two related issues. The first is the degree to which professionals working will resist or accommodate moves to undo organisational distinctions and so allow for more flexible and person-centred ways of working. The spectre of the recalcitrant professional haunts much of this literature as an unquiet ghost who impedes the successful implementation of more integrated ways of working. Often this is conceptualised as a problem of professional "culture". Each profession, Hall argues, "has a different culture, including values, beliefs, attitudes, customs and behaviours" (2005: 188). This culture is inculcated within professionals through the process of training by which they come to recognise themselves as a distinct group and so engage in "boundary-work" which protects "their" domain against the encroachment of laypeople and other professionals (Hall 2005: 189). This "professional system", as Martin-Rodriguez et al., argue, almost inevitably inhibits integration since "it promotes a perspective that is in direct opposition to the rationale for collaboration" and "the dynamics of professionalization", therefore, "lead to a differentiation of professionals and to territorial behaviours within the team" (2005: 136-137).

The second workforce issue is most commonly framed as having to do with leadership. Numerous studies argue that effective leadership is the key to making the successful transition to more seamless ways of working (cf. Martin & Rogers 2004). This quality is usually invested in a person or few persons who are tasked with bringing the integrative vision into reality. Leaders, to quote Martin, "work with others to visualise how change could make an improvement, they create a climate in which the plans for change are widely accepted and they stimulate action to achieve the change" (2003: 5). In this sense, the notion of the effective leader is in defined against and in relation to the recalcitrant professional, where the later constitutes and embodies the barriers which frustrate aspirations to integration and the former works carefully and collaboratively to dismantle these barriers and so "develop the capacity of organisations to change and work in partnership" (Martin & Rogers 2004: 6).

Leaders as Boundary-Spanners

Within the context of aspirations towards the integration of services the "leader" should, therefore, be a "boundary spanner." The term "boundary spanner" has been enrolled to variously describe the individuals who work between defined organisational, sectorial or professional boundaries

(Williams, 2002). Long et al (2013) conducted a systematic review of boundary spanning activity across sectors. They found that the presence of "brokers" who acted to bring collaborative networks together brought significant value to organisations, including improving co-operation, innovation and increasing efficiency. Being a boundary spanner brought many benefits to the individual, including increased social capital, personal power and the chance of promotion. The review also highlighted the costs of boundary spanning, particularly to the boundary spanner who is in danger of becoming overwhelmed by their role.

Focussed on the public sector specifically, Williams (2011) identifies four roles of a boundary spanner: the reticulist, who makes the connections; the entrepreneur, who makes things happen; the interpreter and communicator, who manages relationships; and the organiser, who keeps things together. Interviews and survey research with individuals occupying boundary spanning roles highlight a range of competencies required for successful boundary spanning, including networking, negotiation, and conflict resolution and planning. With specific reference to moves to constitute more seamless services the boundary spanner, almost by definition, becomes key to successful structural integration.

The paradox, however, is that, as services in Scotland and elsewhere make moves to constitute more multidisciplinary, collaborative and finally integrated services middle managers have effectively had the role of boundary-spanning thrust upon them without necessarily being furnished with the tools and techniques required to undertake this work. This is all the more problematic in that many people who find themselves moved into boundary-spanning roles had been trained and socialised as "recalcitrant professionals". They are, of course, not necessarily recalcitrant, and it is quite possible that people find themselves put forward to inhabit boundary-spanning roles because they have demonstrated a capacity to undertake such work; nonetheless, there is a question as to how someone who has trained and work as social worker, nurse, occupational therapist etc. can become a boundary-spanning leader.

Educating for Integration

To achieve integration we need less recalcitrant professionals and more effective leaders who are able to act as boundary-spanners and in doing so transform ways of working. This is a workforce development issue. Essentially there are two questions: 1) how can we encourage doctors, nurses, social workers, allied health professionals, etc. to be less territorial, less concerned with maintaining and protecting "traditional" professional identities and so more open towards the facilitating, rather

than frustrating, moves towards the constitution of more integrated services? And 2) how can we build leadership capacity with the public sector which would enable us to overcome institutional and cultural barriers and to drive forward the required reconfiguration of ways of working.

When it comes to the issues of integration and fostering a culture of interprofessional collaboration the first of these questions has received more academic attention than the second. Some of this has focussed on the informal and everyday processes of learning that take place particularly in collocated interdisciplinary teams. There is, however, a pervasive sense that, to quote Sargent, Loney & Murphy (2008) "contact is not enough" and the building of effective integrated teams requires a complex set of competencies that cannot simply be picked up as one goes along but are best acquired through a more the formal processes of professional education (Sargent, Loney & Murphy 2008: 233). What is generally advocated is some form of prequalification "interprofessional education" (IPE) that is "built into the mainstream of professional education for all health and social care professionals" (Barr & Ross 2006: 96).

The much discussed virtues of IPE are various (cf. Fook et. al. 2013; Thistlethwaite & Moran 2010; Walsh et. al. 2005). Learning with other professionals provides an environment in which practitioners come "to respect and understand the contribution, skills and expertise of others" which in turn will "enable better communication and collaboration for the benefit of service users" (Fook et. al. 2013: 1). IPE also supports the acquisition of more "generic" skills that are required of those working in complex multidisciplinary environments and would underpin and enable moves towards the more flexible configuration of work roles. By extension, the ultimate aspiration of IPE is to "to modernize the health and social care workforce by 'educational engineering'" (Barr and Ross 2006: 9). Ideally "IPE should not only contribute to the modernization of service, but also to the modernization of professional education systems by the back door" (Barr and Ross 2006: 9). Whether these aspirations and ideals have been realised in practice is, of course, another matter and case studies and systematic reviews of the evidence have presented a mixed, if on the whole broadly positive, assessment of the learning outcomes of IPE (cf. Hammick et. al. 2007).

In contrast, the ways in which people learn to lead and drive forward the development of more integrated services are profoundly under-researched and so poorly evaluated and understood (although in relation to the training of health service managers see Cowling and Newman 1994 and Loan-Clarke 1996). More specifically, despite the emphasis on importance on leadership and the role of the manager described above, there have been no studies of how people become the leaders and managers who have the boundary-spanning capabilities required to drive forward the integration

agenda and transform policy into practice. The issue is then how we may imagine an IPE for those who lead on projects designed to better integrate services at a local, or perhaps national, level? We recognise that this is difficult work with peculiar demands. We also recognise that the boundary-spanning competencies and capabilities required to lead on the integration agenda cannot simply be "picked up". We would suggest, therefore, that there is a role for formal education in supporting those in management positions who are, in various ways tasked within facilitating the better integration of services.

To consider how programmes of formal education may be designed to support managers to enhance their boundary-spanning capabilities in the context of aspirations to integrate health and social care services, we will reflect on our own experience of designing and delivering a master's programme in Integrated Service Improvement at the University of Edinburgh. Our conclusions are based on the experience of working with successive cohorts of students all of who shared the ambition to become more effective leaders who had the skills to work successfully in multidisciplinary environments and, in so doing, move towards the creation of a more seamless provision of care. These reflections are supplemented by a systematic review of the programme documentation, student feedback surveys and the various pieces of written work submitted by students over the past five years, up to the end of 2014.

The Postgraduate Programme in Integrated Service Improvement

The Postgraduate Programme in Integrated Service Improvement: Health and Social Care is a part time programme for senior professionals. The programme is flexible, enabling students to take individual courses for Continuing Professional Development or to work towards a Postgraduate Certificate, Diploma or MSc. The programme is taught as blended learning with students attending the University for full-day seminars and completing structured exercises between classes. This structure ensures students integrate theory, research and practice on an ongoing basis and enables students to access the programme from across Scotland and beyond. The programme emerged from collaboration between an academic (GH) and Kate Bell, a senior manager within the NHS and the mix of input from academia, policy and practice continues. The programme started in 2005 as a Certificate and was developed into a full MSc in 2009.

A central feature of the programme has been that content and delivery have evolved in response both to the shifting health and social care landscape and ongoing feedback from students and staff. Sustaining relationships with a network of policy makers and practitioners is critical to this end. The collaborative approach to curriculum development has led to the development of a suite of courses

that provide space for students to critically examine the latest developments in policy and practice whilst retaining a rigorous academic grounding. Courses focus both on substantive issues, such as integration, quality, personalisation and outcomes and the development of specific skills, including project management, policy analysis, qualitative and quantitative data analysis, mentoring and coaching.

Over the past ten years more than 160 students have participated in the programme from across health and social care organisations in Scotland, including: local authorities; the NHS; community health and social care partnerships; voluntary sector organisations; national improvement bodies; and the Scottish Government. Students occupy diverse roles, working in strategic, business services and operational arms of their organisations.

Student experiences: complex, shifting and hidden boundaries

Unsurprisingly, given the nature of the programme, all students bring experiences of boundary spanning. In some cases students occupy roles that have been specifically developed to deliver collaboration at local and national levels, such as the Lead for Intermediate Care, who is a nurse by profession, based in a Local Authority and manages 200 staff based in both the NHS and local authority. In most cases, however, students come to the programme from roles where boundary spanning is required to get the job done, as opposed to being the explicit purpose of the role.

Students often bring practical concerns to class, with negotiations of IT systems unsuitable for inter-organisational work a common example. These discussions open up general issues in management across boundaries, though tales of conflict over professional and organisational territory have been relatively rare. Indeed, as Hudson (2002) proposes, most students report long standing collaborative relationships with colleagues from different professional and organisational backgrounds. This experience is evidenced by the ease with which students working across health and social care are able to communicate and collaborate in class, a finding echoed in a student dissertation, which found middle managers in a local context did not experience cultural differences between organisations as a particular barrier to effective collaboration (Lunts 2012).

From the inception of the programme students have identified a range of more intractable boundary spanning issues that transcend organisational and professional boundaries. Firstly, the complex and shifting nature of the collaborative terrain within which students operate in and of itself provides a significant barrier to collaboration. Most managers on the programme are unable to comprehensively describe their local collaborative context, with managers from the same locality

having a different understanding of the key partners and relationships between them. This makes the reticulist and co-ordinating functions of the boundary spanner challenging as relationships and perceptions about relationships are fluid. Whilst in the longer term the focus on structural integration in Scotland may reduce complexity and still the pace of change, in the short term the legislation has precipitated the creation of a suite of new extra organisational entities, such as joint strategic commissioning groups, which create new boundaries to work across. More difficult still is working in the context of the 'structural holes' (Long et al, 2013) that have been caused by delays in constituting these new entities. For example one student identified the biggest threat to taking forward a change programme in his local partnership was the delay in appointing the Joint Accountable Officer and the uncertainty and decision making vacuum that this caused.

Arguably the most complex and certainly the most ubiquitous boundary to be spanned by students was that occurring between policy and practice. Many of the students on the programme are in middle management roles leading on policy implementation. Putting policy into practice demands that these students bring together diverse types of knowledge, including knowledge gathered from service users and carers, local and national administrative data, and the views of practitioners, managers and strategic leads. Carlile (2004) provides a conceptualisation of knowledge management across boundaries, which highlights how the challenge increases where parties bring different kinds of knowledge, where knowledge is being used for multiple purposes and where the knowledge is new. Student accounts showed that many of them are routinely working in situations where all three challenges exist. An exemplar of this, commonly discussed within the course on Personalisation and Outcomes, is the challenge of supporting front line staff to adopt new approaches to outcome focussed assessment that involve engaging holistically with the person being assessed whilst also capturing significant amounts of routine data about the person for planning and performance purposes.

Student accounts of working across policy / practice boundary highlights the extent to which the boundary work is hidden and beset by tensions unrecognised by their organisations and policy makers. An example of this raised by several students in commissioning roles is the challenge of reconciling the views of service users and carers alongside a procurement system that values cost above everything else. Thus the transformation of different sources of knowledge to information on which to make operational decisions is profoundly influenced by political factors that determine the forms of knowledge that have most legitimacy within the system.

Reflection on the students' experience as captured by the staff team and considered in light of relevant literature led us to identify four core pedagogical principles underpinning our approach to supporting managers in their boundary spanning work

Principle 1: Ground learning in experience

The need to ground learning in experience was a principle firmly established at the start of the programme, driven by the concern that the programme would provide learning of immediate value and applicability to the students and their organisation. This principle is operationalised through an approach to both formative and summative assessment in which students bring together theory, policy and evidence from research and practice to develop an enhanced understanding of the contexts in which they work. For example in the Qualitative Information and Analysis course, students collect data within their workplace, which they then analyse, present and discuss in an assignment. One student, an NHS locality manager establishing a new multidisciplinary service, used this course to systematically analyse the data gathered at a range of staff engagement events, going beyond 'cherry picking quotes' to produce a more comprehensive account.

This approach has three benefits: Firstly, the production of the assignment creates a tangible output that helps progress work in the student's organisation. Secondly, working in this way encourages the student to both *reflect on action* and to *reflect in action* (Schon, 1983), thereby closing the gap between reflection (and indeed evidence) and practice. Thirdly, by enrolling practice as evidence and interrogating this in light of relevant literature, students are able to contribute to the formal evidence base, including through peer reviewed journal articles (e.g. Lunts, 2012; Mitchell, 2012).

Principle 2: Develop a shared language that transcends organisational context.

Supporting students to make explicit their tacit knowledge is vital to create a common language which can further collaborative working at this level. The health and social care terrain is beset with jargon and linguistic confusion and it has been critical to give students space, through facilitated group working, to clarify and unpack definitions to enable them to work together. Furthermore, it is vital that this shared language transcends the local context enabling students to not only articulate links and differences within the system, but also in relation to more generic concepts and theories. For example in a recent class discussion on the challenges of introducing mentoring and coaching approaches to organisational development, students enthusiastically embraced the language used by Patterson et al (2011) to consider where their different organisations were on the path to more transformative and relational approaches to management.

The development and use of a shared and generic language is an important step in developing a more objective, critical and reflective understanding of the organisation and system in which students work. This is needed if they are to negotiate the kinds of political and epistemological tensions described above and lead on change. Furthermore, it enables them to move from describing the context in which they work to understanding and explaining what is going on. Issues around language have formed the focus of several dissertations, including on outcomes, independence and care. Most recently a student leading on the delivery of integrated older people's services in her locality used her dissertation to explore older people's perspectives of risk. This work found that older people using services had a different view of risk from that of practitioners and the dominant policy rhetoric and that ignoring these differences was reducing outcomes for patients and increasing costs for the service (Wilson, 2014).

Principle 3: Learning is inter-professional and co-produced.

The value of learning with people from across the health and social care system has been emphasised by students since the inception of this programme, reflecting the broader evidence base around inter-professional education (e.g. Walsh et al, 2005). To realise the full potency of IPE it is not enough for students from different professional backgrounds to learn alongside each other. In addition they must be supported to engage as active learners, individually and collectively working to co-produce new transformative understandings of the systems in which they work. The complexity of the terrain means that no one student or tutor can claim more than a partial understanding of any given process or context and that collective interrogation of theory, data, practical experience and research routinely leads to new insights for all involved. This process of co-production is facilitated through classroom discussions, small group working and peer review of assignments. In this way students not only develop an enhanced understanding of the collaborative terrain, but are supported to engage in the spanning of complex, novel, multiple and inter-dependent knowledge boundaries in a safe environment.

A key approach used to achieve this has been asking students early in their time on the programme to work together in small groups to create a network map of a local partnership. This exercise not only provides an opportunity to pool knowledge, but surfaces the structural differences and similarities across the professionals and geographical areas as well as the language used to describe them. Evidence from student evaluations show that these experiences of collaboration in class are important in building confidence for collaboration in the workplace and have led to the creation of lasting collaborative relationships that have extended into the workplace.

Principle 4: Support skill development

As Williams (2002) highlights, effecting the change required to span boundaries requires a range of competencies from communication to entrepreneurialism, and a programme of education for collaboration must support students to develop the skills underpinning these competencies. It is useful to differentiate those academic skills routinely taught in higher education, such as written communication, critical reflection, research methods and use of evidence, from more practical skills more often acquired in the workplace, such as project management and coaching. Experience from the programme highlights how developing practical skills within the rigours of an academic programme supports students in moving beyond mechanistic and technical approaches to the more reflective understanding required to 'manage in the swamp' (Schall, 1995). For example one student described applying a coaching model to manage conflict in an email exchange, evidencing the approach to 'coaching as a way of being' discussed in class. Similarly, in the project management course students are encouraged to move beyond the use of specific IT driven tools to understand and work with the levers of power that are critical to project success.

Probably the most important way in which academic and practical skills need to come together is around the use of evidence. Being able to develop a case for change grounded in a robust understanding of a range of sources of evidence and articulate this in a way that is relevant to the intended audience is central to the entrepreneurial function of a boundary spanner. For example one student used his dissertation to gather qualitative and quantitative data on the impact on demographic changes on the functioning of a home care enablement service. This research showed how increasing demand for care at home services led to increased referrals to enablement, undermining the therapeutic function of this service (Fordyce, 2013).

Experience of working with students on the programme reveals that those in managerial roles are already adept at communicating with different audiences in the workplace. Where they have less confidence is around use of evidence. In end of year focus groups students have highlighted how the discipline of writing academically has greatly enhanced their confidence in communicating evidence generally, even if the specific skills and academic conventions learnt during the programme are not used again.

Education for integration: integrating the principles into practice

The key message from this review of the experiences of student and staff over ten years of educating for integration at the University of Edinburgh is that managing in collaborative contexts is

complex and approaches to supporting managers need to equip them to understand and work with this complexity. The ability to reflect and analyse critically is central to the acquisition of all the boundary spanning competencies articulated by Williams(2002) and this is something that takes time and space to develop (Schon, 1983). In many respects higher education is an ideal context in which to advance education for integration, with postgraduate education in particular a well-established platform for learning that is critical, self-directed and that engages with complexity. To date higher education establishments have been slow to recognise and fill this gap.

Formal programmes of collaborative education will never meet the education needs of public service managers alone. If collaborative reform, such as the Integration of Health and Social Care in Scotland is to succeed organisations and need to find ways to integrate the pedagogical principles outlined above into mainstream workforce development programmes. This demands an approach to Organisational Development that goes beyond staff training with a view to demonstration of desired levels of competence in specific skills and creates space for managers to work together to explore new ideas, engage with evidence and share and learn from practice, both good and bad. This shift cannot be made overnight and managers need support to develop the skills required to learn collaboratively, as well as permission to think critically. In turn organisations involved in public service reform need to learn from these processes of evidence sharing and critical reflection, integrating new insights into the ongoing development of collaborative processes.

References

Barr, H. & Ross, F. (2006). Mainstreaming interprofessional education in the United Kingdom: a position paper. *Journal of Interprofessional Care* 20 (2), 96-104.

Cameron, A., Lart, R., Bostock, L., & Coomber, C. (2014). Factors that promote and hinder joint and integrated working between health and social care services: a review of research literature. *Health & social care in the community*, 22(3), 225-233.

Carlile, P. (2004) Transferring, Translating, and Transforming: An Integrative Framework for Managing Knowledge across Boundaries. *Organization Science*, 15(5) 555-568

Cowling, A., & Newman, K. (1994). Turning doctors into managers: an evaluation of a major NHS initiative to improve the managerial capabilities of medical consultants. *Human Resource Management Journal*, 4(4), 1-13.

Fook, J., D'Avray, L., Norrie, C., Psoinos, M., Lamb, B., & Ross, F. (2013). Taking the long view: exploring the development of interprofessional education. *Journal of Interprofessional Care* 27 (4), 286-291.

Fordyce, S (2013) *Old age doesn't come alone: a case study on the impact of the ageing population of a Scottish local authority's care at home service*. MSc Dissertation, University of Edinburgh. Accessed at http://www.researchunbound.org.uk/aging/wp-content/uploads/sites/17/2014/02/Stuart-Fordyce-Old-age-dissertation.pdf 27.8.15

Hall, P. (2005). Interprofessional teamwork: professional cultures as barriers. *Journal of Interprofessional Care* 19 (s1), 188-196.

Hammick, M., Freeth, D., Koppel, I., Reeves, S., and Barr, H. (2007). A best evidence systematic review of interprofessional education: BEME Guide no. 9. *Medical Teacher* 29, 735-751.

Hudson, B. (2002) Interprofessionality in health and social care: the Achilles' heel of partnership. *Journal of Interprofessional Care* 16 (1), 7-17.

Loan-Clarke, J. (1996). Health-care professionals and management development. *Journal of Management in Medicine* 10(6), 24-35.

Long, J. C., Cunningham, F., & Braithwaite, C. (2013), Brides, brokers and boundary spanners in collaborative networks: a systematic review. *BMC health Services Research* 13, 158.

Lunts, P. (2012) Change management in integrated care: what helps and hinders middle managers – a case study. *Journal of Integrated Care* 20 (4), 246-256.

Martin, V. (2003). *Leading change in health and social care*. London: Routledge.

Martin, V. and Rogers, A. (2004). L*eading interprofessional teams in health and social care.* Abingdon and New York: Routledge.

Martin-Rodriguez, L., Beaulieu, D., D'Amour, D. & Ferrada-Videla, M. (2005). The determinants of successful collaboration: a review of theoretical and empirical studies. *Journal of Interprofessional Care* 19 (s1), 133-147.

Mitchell F. (2012). Self-directed support and disabled young people in transition (part1). *Journal of Integrated Care* 20(1), 51-61.

Patterson, M.; Nolan, M.; Rick, J.; Brown, J.; Adams, R., & Musson, G. (2011). *From metrics to meaning: culture change and quality of acute hospital care for older people*. London: HMSO.

Petch, A. (2008). *Health and social care: establishing a Joint Future?* Edinburgh: Dunedin

Petch, A. (2011). *An evidence base for the delivery of adult services*. Report commissioned by Association of the Directors of Social Work.

Sargent, J., Loney, E. and Murphy, G. 2008. Effective interprofessional teams: "contact is not enough" to build a team. *Journal of the Continuing Education in the Health Professions* 28 (4): 228-234.

Schall, E. (1995). Learning to love the swamp: Reshaping education for public service. *Journal of Policy Analysis and Management*, 14(2), 202-220.

Schon, D. (1983). *The reflective practitioner, how professionals think in action*. Basic Books.

Thistlethwaite, J., & Moran, M. (2010). Learning outcomes for interprofessional education (IPE): Literature review and synthesis. *Journal of interprofessional care* 24(5), 503-513.

Walsh, C., Gordon, M. F., Marshall, M., Wilson, F. & Hunt, T. (2005). Interprofessional capability: a developing framework for interprofessional education. *Nurse Education in Practice* 5, 230-237.

Williams, P. (2002). The competent boundary spanner. *Public administration* 80 (1), 103-124.

Williams, P. (2011). The life and times of the boundary spanner. *Journal of Integrated Care* 19(3), 26-33.

Wilson, S (2014). *Whose needs are we meeting? Exploring risk at the time of discharge.* Unpublished MSc dissertation, University of Edinburgh.